

## PDD Program Pre-Screening Assessment of Responsible Party

Child's Name: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

	Yes	No
Does the child have a legal guardian**?		
If yes, name of person _____		
<b>** This person may not serve as a Line Therapist.</b>		
Is the Responsible Party a relative of the child?		
If <b>yes</b> , what is the relationship?		
If <b>no</b> , does the Responsible Party live with the child?		
<b>If the answer is "NO" to any of the below shaded questions, please  the assessment.</b>		
If Responsible Party is living outside the child's household, is the Responsible Party accessible?		
Has this Responsible Party agreed to supervise the Line Therapist?		
Is the Responsible Party able to assure that the Line Therapist performs all required duties (e.g. reports to work on time, completes assigned tasks and submits all paper work as required per the child's plan)?		
Is the Responsible Party able to advocate for the child?		
Is the Responsible Party able to communicate and make the child's needs understood?		
Does the Responsible Party possess adequate knowledge about the child's medical condition?		
Comments: _____ _____ _____ _____ _____ _____ _____ 		

Date: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

Per my signature below, I acknowledge all requirements of the Responsible Party and agree to serve as such for this child.

Date: \_\_\_\_\_ Responsible Party: \_\_\_\_\_